Australian Government
Medicare Australia

Australian childhood **immunisation** register

Application for authority to transmit immunisation data electronically

Applicant's name……………………………………………………………………………………………

Medicare provider/ACIR registration number………………………………………………………

Mailing address……………………………………………………………………………………………

……………………………………………………………………………Postcode ……………………

Practice address……………………………………………………………………………………………

……………………………………………………………………………Postcode……………………

Contact telephone number (……)…………………………………Facsimile (……)……………………

Nominated software supplier………………………………………………………………………………

Nominated communications supplier………………………………………………………………………

Minor customer ID… ………………………………………………………………………………………
(3 alphas and 5 numerics code identifying your Site which is supplied by your software supplier)

1. I, the applicant, am a recognised immunisation provider for the purposes of the Australian Childhood Immunisation Register ('the ACIR').

2. I understand that:

   (a) Medicare Australia provides a facility which allows recognised immunisation providers to transmit immunisation data electronically to Medicare Australia to enable Medicare Australia to maintain the ACIR ('Program').

   (b) The immunisation details must be submitted in the formats determined by Medicare Australia. The formats may require change from time to time.

3. I authorise the electronic transfer of data from the location stated above.

4. I acknowledge that I must have the ongoing approval of Medicare Australia to transmit data for the ACIR electronically, and, subject to the approval, I have agreed to participate on the terms and conditions set out in the agreement.

Please return both completed pages to:

Medicare Australia
EDI Coordinator
GPO Box 9822
in your capital city

Immunisation data transfer agreement terms and conditions

1. In consideration of the payments set out in clause 4, I will transmit electronically, immunisation data for the ACIR ('Data') from the location stated on the application form.

2. I will complete a separate application for each location.

3. I will only use computer software which has the current approval of Medicare Australia for the purpose of:
   (a) preparing Data in the format specified for immunisation;
   (b) connecting with the encryption software supplied by Medicare Australia; and
   (c) connecting with a telecommunications service for transmission of the Data.

4. I understand that Medicare Australia will pay the communication charges for the transmission of Data.

5. Resubmitted Data involving clarification or amendment to information previously submitted cannot be submitted electronically.

6. I will take reasonable steps to ensure that any password, electronic mail addresses and other security features of any equipment and software used as part of the Program is kept secure by myself and my employees or agents.

7. I acknowledge that I must have the ongoing approval of Medicare Australia to participate in the Program and, subject to the approval, I have agreed to participate in the Program on the terms and conditions set out in this agreement and to abide by these terms and conditions.

8. Should I cease to be a recognised immunisation provider, I understand that I will cease to be eligible to transmit immunisation Data.

9. If my participation in the Program is ended for any reason, I will cease to use encryption software made available to me by Medicare Australia and I will return the software to Medicare Australia.

10. I understand that Medicare Australia may vary the terms and conditions of this agreement subject to 14 days notice being given to participating providers.

11. Medicare Australia may at any time limit or cancel my participation in the Program if I breach any of these terms and conditions in any way.

12. I understand that I may withdraw my participation in the Program by giving 14 days notice of this to Medicare Australia.

Dated .... day of ...., 20…………..

Full Name of **applicant** (please print)..

Applicant signature...

Name of **witness** (please print)...……………..

Witness signature...

PRIVACY NOTE: The information provided by you on this form will be used by Medicare Australia only, for the purposes of establishing your authority to transmit data to the Australian Childhood Immunisation Register as authorised by law. This information will not be disclosed to any other bodies.